WASHINGTON STATE DEPARTMENT OF HEALTH
EARLY INTERVENTION PROGRAM (EIP)
MESSAGE CODE DESCRIPTION AND/OR INSTRUCTION

This guide supersedes all previous message code descriptions and/or instructions published by the Early Intervention Program (EIP), Washington State Department of Health.

Use this guide when applying payment to assist with maintaining compliance with your contract with the Early Intervention Program (EIP).

EOB	Instruction/Description	
P00	Split payment	Payment has been split between deductible, coinsurance and/or co-pay.
P01	Pay full payment	Client is uninsured and accessing services with EIP as the only payer so services are paid up to full EIP allowed amount.
P02	Payment applied toward deductible	Client is insured; payment may be up to the full EIP allowed amount and is applied to the deductible. Remaining balance may **NOT** be billed to the patient.
P03	Pay during Pre-Exist Condition period	Client is insured and service is paid up to the full EIP allowed amount since it's denied by the primary insurance due to a pre-exist condition. Provider can **NOT** bill client for the balance.
P12	Pay Co-insurance	Client is insured; payment may be up to the full EIP allowed amount and payment was applied to coinsurance. Remaining balance may **NOT** be billed to the patient.
P39	Pay Co-pay	Client is insured; payment may be up to the full EIP allowed amount and payment was applied to co-pay. Remaining balance may **NOT** be billed to the patient.
D00	Deny client is not eligible on Date of Service	Coverage not in effect at the time the service was provided.
D02	Deny Medicaid Coverage	The client may be eligible for Medicaid coverage on DOS. The provider may bill the client or Medicaid/HCA for these services.
D05	Deny exception request	The provider may bill the client for these services.
D10	Deny Client has dental insurance	Clients cannot have primary dental coverage to qualify for this program, so you may bill the client.
D11	Deny missing EOB info from primary insurance.	The provider must submit a copy of the primary EOB with the claim to be reprocessed. You may **NOT** bill the client during this time.
D12	Deny Co-insurance not covered on DOS	Billing is prior to 4/1/2010. We did not pay co-insurance before that date. The provider may bill the client for these services.
D13	Deny primary insurance Pd in full	The submitted EOB indicates no client financial responsibility since the primary insurance paid their full contracted amount. The provider may **NOT** bill the client for these services.
D14	Deny Primary insurance Pd over EIP allowed amount.	Client is insured; payment may be up to the full EIP allowed amount and the submitted EOB indicates that the primary insurance applied payment/deductible or coinsurance assignment over the Early Intervention Program (EIP) maximum allowed amount. The provider may **NOT** bill the client for these services.
D15	Deny Exceeds EIP allowed deductible amount.	Deductible Max Paid for Client. The provider may only bill the client the EIP allowed amount for the service.
D17	Dental Max Paid	$2500.00 EIP dental Max has been Paid. The provider may only bill the client the EIP allowed amount for the service.
D30	Deny procedure not covered on DOS	Procedure is not an EIP covered service. The provider may bill the client for these services.
D31	Claim over 9 months old	Claim not submitted within required time limits. You may appeal this denial if you have documented proof that the client NEVER provided Early Intervention Program coverage information. You may **NOT** bill the Client.

EOB	Instruction/Description	
D32	Duplicate Claim	The claim was previously submitted and paid. Contact the Early Intervention Program if you cannot locate a payment for the service date.
D33	Deny Provider not contracted on DOS	Providers must have an active contract with the Early Intervention Program (EIP) to be reimbursed. The provider may bill the client for these services.
D34	Deny no Preauthorization	The billed service is not an allowed service or was not preauthorized.
D35	Insufficient Information received with claim	You must provide a copy of a detailed* explanation of benefits from the primary insurance that has amount paid for deductible, Co-payment and Co-insurance listed for **each** service. You may **NOT** bill the client during this time.
D36	Deny Duplicate Service Paid to other provider	The same service was billed by another provider and paid. You may re-bill the claim with documentation showing the services were performed separately for reconsideration. You may **NOT** bill the client.
D37	Deny service considered included in other service	This service is considered complimentary to another service performed on the same day. You may **NOT** bill the client.
D38	Deny Incomplete Client Application	Client has not provided all needed information to complete the application process. Please check client's ID card for coverage dates.
D39	Deny Co-pay not covered on DOS	Billing is prior to 4/1/2010. We did not pay co-insurance before that date. The provider may bill the client for these services.
D40	Deny service ineligible for coordination of benefits on DOS	• The service was performed after December 31, 2010, and not allowed by the primary insurance. • The provider may bill the client for these services.
D41	Deny procedure not allowed in Group 2	This service is not allowed in Group 2 coverage. The provider may only bill the client the EIP allowed amount for the service.
D42	Deny procedure not allowed in Group 3	This service is not allowed in Group 3 coverage. The provider may only bill the client the EIP allowed amount for the service.
D43	Emergency room and related services are not covered.	The Early Intervention Program (EIP) does not cover emergency, in-patient or most radiology services.
E01	Partial payment – dental max exceeded	$2500.00 EIP dental Max has been Paid. The provider may only bill the client the EIP allowed amount for the service.
E02	Partial payment – deductible max exceeded	Deductible Max Paid for Client. The provider may only bill the client the EIP allowed amount for the service.
E04	Exception authorized	The exception request has been approved and is paid at full EIP allowed amount. Provider can **NOT** bill client for balance.
E05	Claim reprocessed to correct error	The provider may **NOT** bill the client for these services while correction is being processed.
E11	Resubmit with primary insurance EOB	The provider must submit a detailed* copy primary EOB with the claim to be reprocessed. You may **NOT** bill the client during this time.
E12	Resubmit with Regence EOB	The provider must submit a detailed* copy primary EOB with the claim to be reprocessed. You may **NOT** bill the client during this time.
E13	Resubmit with Premera EOB	The provider must submit a detailed* copy primary EOB with the claim to be reprocessed. You may **NOT** bill the client during this time.
E14	Resubmit with Medicare EOB	The provider must submit a detailed* copy primary EOB with the claim to be reprocessed. You may **NOT** bill the client during this time.
E15	Resubmit with PCIP-WA EOB	The provider must submit a detailed* copy primary EOB with the claim to be reprocessed. You may **NOT** bill the client during this time.
E16	Resubmit with WSHIP EOB	The provider must submit a detailed* copy primary EOB with the claim to be reprocessed. You may **NOT** bill the client during this time.
E17	Less than $500 Dental allowance remaining	Please verify coverage before the next visit.

*Detailed: Documentation must display itemize deductible, co-pay **and** coinsurance amounts for each service line item on claim.

If this information is being sent to the wrong address, please notify our office immediately at (877) 376-9316.